

***Federal Fiscal Year 2001  
FRAMEWORK FOR ANNUAL REPORT  
OF STATE CHILDREN'S HEALTH INSURANCE PLANS  
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT***

**Preamble**

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- ❖ Recognize the *diversity* of State approaches to SCHIP and allow States *flexibility* to highlight key accomplishments and progress of their SCHIP programs, **AND**
- ❖ Provide *consistency* across States in the structure, content, and format of the report, **AND**
- ❖ Build on data *already collected* by CMS quarterly enrollment and expenditure reports, **AND**
- ❖ Enhance *accessibility* of information to stakeholders on the achievements under Title XXI.

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State/Territory: IDAHO  
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

\_\_\_\_\_  
(Signature of Agency Head)

SCHIP Program Name(s): CHIP

SCHIP Program Type:

- ☒ Medicaid SCHIP Expansion Only  
☐ Separate SCHIP Program Only  
☐ Combination of the above

Reporting Period: Federal Fiscal Year 2001 (10/1/2000-9/30/2001)

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Submission Date: December 31, 2001

*(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002)  
Please cc Cynthia Pernice at NASHP ([cpernice@nashp.org](mailto:cpernice@nashp.org))*

## **SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS**

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*This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).*

**1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.**

*Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.*

- A. Program eligibility- NC
- B. Enrollment process - NC
- C. Presumptive eligibility - NC
- D. Continuous eligibility - NC
- E. Outreach/marketing campaigns

The following changes have been make to the SCHIP program outreach/marketing campaign.

- The Idaho Department of Health and Welfare (DHW) participated with the Robert Wood Johnson Foundation Covering Kids activity of promoting CHIP in a Spring Healthy Children initiative. During March 2001, both radio and television advertisements were run in the Boise media market.
- The Carpenter's Union provided approximately \$40,000 in funds to promote the CHIP program statewide with radio advertisements. In addition to the radio spots, a local union chapter went door-to-door in a heavily populated Hispanic neighborhood and provided CHIP information to families.
- Due to legislative directive, DHW did not fund television or radio advertisements.
- In addition to providing families and community organizations education about CHIP the Americorps VISTA (Volunteers in Service to America) workers are providing CHIP clients education and information on how to access health care and additional community programs as well as helping to define areas where children are having difficulty accessing care.

- F. Eligibility determination process - NC

- G. Eligibility redetermination process - Idaho implemented a simplified renewal process October 1, 2000. This process was designed to increase the retention of current CHIP enrollees by decreasing closures due to unverified circumstances.
- H. Benefit structure – NC
- I. Cost-sharing policies- NC
- J. Crowd-out policies - NC
- K. Delivery system - NC
- L. Coordination with other programs (especially private insurance and Medicaid) - NC
- M. Screen and enroll process - NC
- N. Application - Idaho has not made any significant structural changes to the Application for Assistance since November 1999. Work continues around simplifying the instructions and questions to better serve our citizens. Further, we continued to provide the application in both English and Spanish.
- O. Other - Idaho is currently rewriting all eligibility letters to families and these new letters are being translated into Spanish. All letters are written at a sixth grade reading level if possible. New automation is being completed to refine the letter to be more family friendly and readable. We expect to wrap up the project during the second quarter of 2002.

**1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.**

- A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

Idaho continues to make significant progress in reducing the number of uninsured children through enrollment in Title XIX and XXI programs. In FFY 01, Idaho enrolled an additional 18,889 children, raising the total number of children enrolled in these programs from 76,076 to 94,965, an increase of 24.8%. However, this does not reflect an actual equivalent decrease in the number of uninsured children in Idaho. While CHIP enrollment has grown, the Idaho population has also grown and the Idaho economy began a downturn in the last quarter of the federal fiscal year. That combination would cause an increase in the number of uninsured children, but there is no accurate data on which to estimate that increase.

The data for the number of enrolled children comes from the Divisions of Welfare and Medicaid in the Idaho Department of Health and Welfare. It is derived from actual caseload data in the

Division of Welfare and actual counts of eligible children in the Division of Medicaid and comes from the automated information systems in those Divisions.

- B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

In FFY 01, an additional 15,188 children were enrolled in Medicaid programs, primarily the Pregnant Women and Children Program. This represents a 22.2% increase in enrollment. During the same time period, an additional 3,701 children were enrolled in Idaho's CHIP Medicaid expansion program, and increase of 47.4%

The data for the number of enrolled children comes from the Divisions of Welfare and Medicaid in the Idaho Department of Health and Welfare. It is derived from actual caseload data in the Division of Welfare and actual counts of eligible children in the Division of Medicaid and comes from the automated information systems in those Divisions.

- C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

In March 2001, Idaho was awarded a one-year planning grant by the Health Resources and Services Administration to study the number of uninsured citizens in Idaho and to develop a set of strategies to significantly reduce that number. Over the past six months a public-private partnership of state agencies, health care providers and organizations, health insurers, business leaders, universities, and other stakeholders have been refining data on the uninsured, analyzing the data, reviewing options, and developing the strategies for Idaho that can be used to provide coverage to uninsured people. That group will have a set of recommendations and action items developed by Spring 2002.

A significant achievement of the group to date has been educating legislators, key policy makers, and the business community that 80% of the uninsured are in working families (see Appendix A, "Idahoans Without Health Insurance, A Data Report"). That fact has impacted most of the discussions in a positive manner and increased the motivation to find solutions.

- D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

\_\_\_\_\_ No, skip to 1.3

XX Yes, what is the new baseline?

The new baseline estimate of uninsured children in Idaho is that there were 65,000 uninsured children eligible for SCHIP/Medicaid at the inception of the program, of which 13,500 were SCHIP eligible.

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

For the March 2000 Evaluation, Idaho reported a baseline of 34,805 children eligible for either Medicaid or SCHIP programs. Of that total, Idaho estimated that 8,701 were eligible for SCHIP. By September 30, 2001 the total enrollment increases in both programs were 40,141 children, 32,372 children in Title XIX Medicaid and 7,769 children in Idaho CHIP. September 30 enrollment in Idaho CHIP is 11,504 children. These enrollment figures are in excess of the projected enrollment done for the March 2000 report.

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

In FFY 01, two different reviews were undertaken to revise the estimates of uninsured children in Idaho. The first effort was led by the Department of Health and Welfare in October 2000. A work group of researchers was convened from the Division of Health, Boise State University, and the Idaho Hospital Association, along with representatives from the Division of Medicaid, the Covering Kids Project, and community stakeholders. The group reviewed the previous data in addition to national estimates from Kids Count, the Census Bureau, and the American Academy of Pediatrics. It also reviewed data from the Behavioral Risk Factor Surveillance System, conducted by the Division of Health in cooperation with the Centers for Disease Control. The phone survey sample size is large enough to create statistically significant responses for each Health District in Idaho. While the survey focuses on adults, it does ask questions about coverage for children in the household. The result of that survey estimated that there were 40,000 uninsured children at the end of CY 99 eligible for Medicaid/SCHIP. At the same time, the American Academy of Pediatrics estimated that Idaho had a total of 72,000 uninsured children and that as many as 75% of those could be eligible. The group concluded that total enrollment in SCHIP/Medicaid could reach 110,000 if all uninsured children were enrolled.

In early 2001, as a function of the HRSA uninsured planning grant, a data work group led by Boise State University examined data to develop estimates of the numbers of uninsured Idahoans. All previous work was reviewed, along with 2000 Census data, 2000 BRFSS data, Idaho tax data, employer survey data, and focus group information. That group arrived at an estimate of 48,000 uninsured children at the end of CY 00, of which 28,800 were eligible for SCHIP/Medicaid. If this estimate is added to the 83,000 children enrolled in SCHIP/Medicaid at the end of the year, it leads to a total possible number of enrollees of 111,800, which is in line with the estimates of the first group.

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Idaho believes that this current estimate is a significant improvement over previous estimates. It is based upon statistically valid information from the US Census Bureau and the Behavioral Risk Factor Surveillance Survey, analysis by research statisticians, and a review of all current data available to Idaho. Trends in actual enrollment data also point to the accuracy of the estimate.

However, these figures may still be underestimates due to:

- The possibility of the Census undercounting Hispanic and Native American populations.
- The fact that the BRFSS is a phone survey; low income families without phones would not be contacted.
- The recent economic downturn is causing many families to lose insurance and to fall into income categories that would make their children eligible for SCHIP/Medicaid.

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

If Idaho had not changed the baseline, it would have achieved over 100% enrollment of eligible children. That would have slowed any initiative to cover other uninsured children. Changing the baseline is necessary for accurate fiscal estimates and to devise appropriate enrollment strategies.

**1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).**

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

- Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
- Column 2: List the performance goals for each strategic objective.
- Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

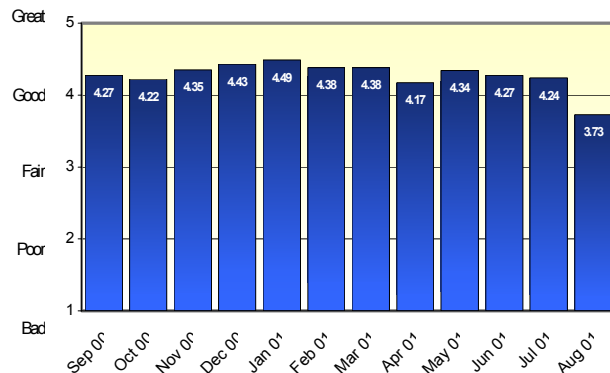
*Note: If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3.*

| <b>Table 1.3</b><br>(1)<br>Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation) | (2)<br>Performance Goals for each Strategic Objective  | (3)<br>Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)   |
|--|--|---|
| <b>Objectives related to Reducing the Number of Uninsured Children</b>   |  |   |
| To enroll 35,000 uninsured children (10/99 estimate) in Title XIX and XXI health programs.                                 | The targeted increase in the enrollment of uninsured children:<br>FY 2000: 8,000<br>FY 2001: 8,000<br>FY 2002: 8,000<br>FY 2003: 8,000 | Data Sources: Enrollment data from the Division of Medicaid AIM system.<br><br>Methodology: Annual increase in enrollment of uninsured children in both programs compared to the previous federal fiscal year.<br><br>The total number of new uninsured children enrolled in both programs compared to the base number of enrollees as of 9/30/99<br><br>Numerator: Number of enrollees on 9/30/01: 94,965<br><br>Denominator: Number of enrollees on 9/30/99: 54,824 |

|   |   |  |
|---|---|--|
|   |   | Progress Summary: As of 9/30/01, Idaho has enrolled an additional 40,141 children, an increase of 73.2% in the number of enrolled children.  |
| <b>To design and implement a sustainable, community-based education and outreach program.</b> | <p>State level and regional outreach and education plans are developed and implemented by 12/31/00.</p> <p>Applications and application assistance are available to target groups in a minimum of 75% of Head Start, WIC, and Migrant and Community Health sites and 90% of birthing hospitals, with a total of at least 5 sites per region, one of which is a school, by 12/31/00.</p> | <p>Data Sources: Division of Medicaid CHIP Outreach Coordinator</p> <p>Outreach plans: Completed and implemented.</p> <p>Applications and application assistance: NC, available at 100% of identified locations.</p>   |
| <b>Objectives Related to SCHIP Enrollment</b>   |   |  |
| To enroll 8,000 uninsured children (10/99 estimate) in the Title XXI health program.          | <p>The targeted increase in the enrollment of uninsured children:</p> <p>FY 2000: 2,000<br/>FY 2001: 2,000<br/>FY 2002: 2,000<br/>FY 2003: 2,000</p>  | <p>Data Sources: Enrollment data from the Division of Medicaid AIM system.</p> <p>Methodology: Annual increase in enrollment of uninsured children compared to the previous federal fiscal year.</p> <p>Progress Summary: The total number of new uninsured children enrolled each year.</p> <p>Numerator: Number of enrollees on 9/30/01: 11,504</p> <p>Denominator: Number of enrollees on 9/30/99: 3,735</p> <p>Progress Summary: As of 9/30/01, Idaho had increased enrollment by 7,769 children, a 208% increase.</p> |

|   |  |  |
|---|--|--|
| <p>To simplify and streamline the application and enrollment process.</p> | <p>The application will be customer friendly, 4 pages long, &amp; only request minimum required information by 12/31/99.</p> <p>Applications can be mailed and children enrolled without a required interview by 12/31/99.</p> <p>Results of the customer surveys will be used to make adjustments as indicated by 12/31/00.</p> | <p>Using stakeholder focus groups, Idaho refined the 4 page application in Spring 2001 to make the form easier to complete and use.</p> <p>NC</p> <p>Stakeholder focus groups, rather than the surveys, were used to identify the adjustments to the application.</p> <p>Data Sources: Division of Welfare</p> <p>Methodology: Customer satisfaction surveys distributed at time of application and with notices.</p> <p>Progress Summary: During FFY 01, Idaho received 1,988 satisfaction surveys. The customer satisfaction score on a 5 point scale was 3.73. 87% of the respondents felt they were treated with courtesy and respect.</p> |
|---|--|--|

**Applicant survey results of "Overall Experience" with the Health and Welfare office:** "What are our applicants for services saying?" Input is vital in our efforts to listen to, understand, and respond to the needs of people seeking our services. In order to solicit this input, a survey card is attached to each application for Assistance (AFA) given out in DHW field offices. Applicants are asked to rate the overall experience in their office as "Great", "Good", "Fair", "Poor", or "Bad". A monthly average of the responses is shown. Though not statistically valid, such data does provide helpful baseline information and can help point out areas that need additional follow up through tools such as focus groups or more detailed questionnaires.



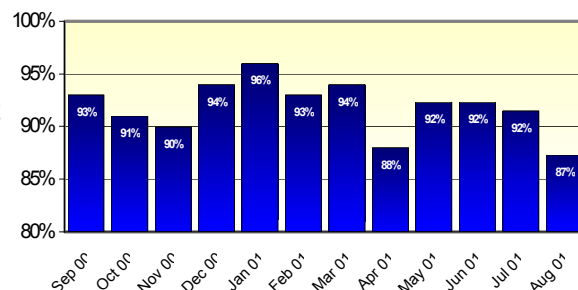
**Customers' overall satisfaction (scale of 5) in**  
(displayed on chart on right)

**3.73**

**Trend:** Most applicants are satisfied with their overall experience.

#### Applicant survey monthly responses to the question of courteous treatment:

Applicants are asked to respond with a "Yes" or "No" as to whether they felt they were treated with courtesy and respect during their office visit. The percentage of "Yes" responses are graphed on the chart to the right. Again, the data is not statistically valid, but provides helpful baseline information of the applicant's perception and is a starting point for future study.



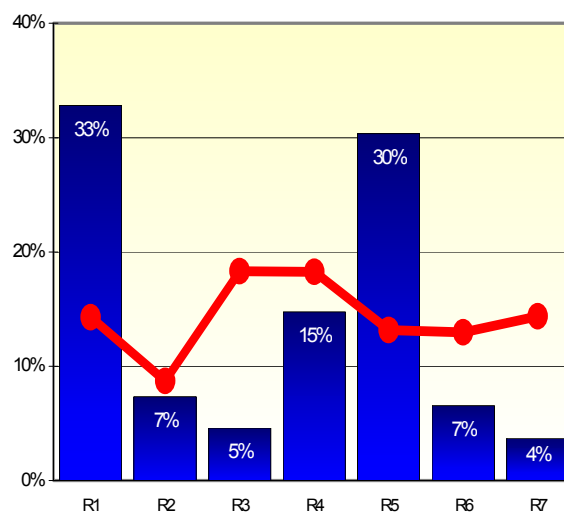
**Percent of customers treated with respect in**  
(displayed on chart on right)

**87%**

**Trend:** Most applicants feel they were treated with courtesy. The level of courtesy perceived by applicants and their overall experience (as shown in the previous measure) are similarly high.

**Applicant survey responses by region:** The total number of survey cards returned by region in the past 12 months are shown in the blue bars. The estimated regional population at or below 150% of poverty is shown in the table below and as a red line on the chart.

| Area  | Surveys returned<br>Blue |         | Population at or below<br>150% of Poverty Red line |         |
|-------|--------------------------|---------|--|---------|
|       | Number                   | Percent | Number   | Percent |
| R1    | 652                      | 33%     | 40,506   | 14%     |
| R2    | 146                      | 7%      | 24,715   | 9%      |
| R3    | 91                       | 5%      | 52,050   | 18%     |
| R4    | 293                      | 15%     | 51,756   | 18%     |
| R5    | 603                      | 30%     | 37,335   | 13%     |
| R6    | 130                      | 7%      | 36,784   | 13%     |
| R7    | 73                       | 4%      | 40,744   | 14%     |
| Total | 1,988                    | 100%    | 283,890  | 100%    |



**Survey cards received in the twelve months ending**  
(NOT displayed on chart; sum of table, above)

**October, 2001**  
**1,988**

Regional success in receiving customer survey feedback varies considerably. Some regions are receiving survey feedback at twice the percentage of their low income population, others are receiving feedback at one-half the percentage of their low income population.

|   |   |   |
|---|---|---|
| To retain enrolled children in Title XXI and XIX programs.                                | Increase in mean and mode length of enrollment of at least 1 month in each of the next three fiscal years for Title XXI participants                          | <p>Data Sources: Division of Medicaid information system</p> <p>Methodology: Track length of enrollment periods for children, trend the data each quarter.</p> <p>Numerator: New mean and mode each quarter.</p> <p>Denominator: Baseline mean and mode of 6 mo. Mean and 2 mo. Mode established in September 1999.</p> <p>Progress Summary: As of 9/30/01 the mean enrollment period has increased to 9 months and the mode has increased to 3 months. No change from 9/30/00.</p>   |
| <b>Objectives Related to Increasing Medicaid Enrollment</b>                               |   |   |
| To enroll 27,000 uninsured children (10/99 estimate) in Title XIX health programs         | <p>The targeted increase in the enrollment of uninsured children:</p> <p>FY 2000: 6,000</p> <p>FY 2001: 6,000</p> <p>FY 2002: 6,000</p> <p>FY 2003: 6,000</p> | <p>Data Sources: Enrollment data from the Division of Medicaid AIM system.</p> <p>Methodology: Annual increase in enrollment of uninsured children in Title XIX programs compared to the previous federal fiscal year.</p> <p>The total number of new uninsured children enrolled in Title XIX programs compared to the base number of enrollees as of 9/30/99</p> <p>Numerator: Number of enrollees on 9/30/01: 83,461</p> <p>Denominator: Number of enrollees on 9/30/99: 51,089</p> <p>Progress Summary: As of 9/30/01, Idaho had increased enrollment by 32,372 children, an increase of 63% and almost triple the enrollment target.</p> |
| <b>Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)</b> |   |   |
| To ensure that enrolled children have a medical home.                                     | There will be a 10% annual increase in the number of children participating in Healthy Connections and having a primary care provider as a "medical home".    | <p>Data Sources: Division of Medicaid, Healthy Connections (PCCM) Program</p> <p>Methodology: Baseline data on the number of children in the Healthy Connections is known. The data system will track new enrollees in the program</p> <p>Numerator: Number of children enrolled in HC at the beginning of the FFY. 10/1/00: 25,661</p> <p>Denominator: Number of children enrolled in HC at the end of the FFY. 9/30/01: 31,106</p> <p>Progress Summary: Healthy Connection enrollment increased by 5,445 children in FFY 01, a 21% increase.</p>  |

|  |   |  |
|--|---|--|
|  |   | <p>While that met the enrollment target, the overall percentage of children in Healthy Connections dropped from 33.7% on 9/30/00 to 32.7% on 9/30/01.</p> <p>Data Sources: Division of Medicaid, Healthy Connections</p> <p>Methodology: The total number of primary care physicians and physician extenders will be tracked along with those that choose to participate in the Healthy Connections PCCM Program.</p> <p>Numerator: Number of participating physicians and extenders: 830</p> <p>Denominator: Total number of primary care physicians and extenders: 1270 (This number has been revised down from last year due to more accurate data collection)</p> <p>Progress Summary: 65% of Idaho's primary care physicians participate in the Healthy Connections PCCM Program. Idaho is finding it challenging to build the pool of participating primary care providers. Many of the currently participating providers limit their practice to existing patients or have a monthly cap on new patients, making it difficult for enrollees who want to participate to be able to do so. Access is a priority work area for the Department of Health and Welfare in FFY 01.</p> |
| <b>Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)</b> |   |  |
| To ensure that enrolled children receive appropriate and necessary medical care.       | <p>90% of enrolled children will have up-to-date, age-appropriate vaccinations.</p> <p>80% of enrolled children age 12 months and younger will have received appropriate preventive care.</p> | <p>Data Sources: Division of Medicaid information system, Division of Health Immunization Registry</p> <p>Methodology: Claims data will be reviewed for immunization and preventive care visits. The immunization registry is being used to track immunization levels.</p> <p>Numerator: Number of children with up-to-date immunizations and preventive care visits.</p> <p>Denominator: Total number of Title XIX and XXI children.</p> <p>Progress Summary: At this time, Idaho is examining the data collection criteria of reporting wellness visits. Preliminary data indicates that percentage of children under one year old is rising slightly (47% in FFY00 to 50% in FFY01), however this is believed to be currently underreported.</p>  |

|   |   |  |
|---|---|--|
|   |   | Immunizations: For the first three series of shots, Idaho's rate of immunizations is in the low 90s. By the time children are ready to go to school the rate is approximately 95%. Rates reflect a decline in the percentage for the 2 year old age group. |
| <b>Other Objectives</b>                                   |   |  |
| To implement a quality improvement process for Idaho CHIP | A Quality Improvement Committee will be convened to review progress toward implementation of CHIP | NC   |

**1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.**

Idaho is meeting its performance goals related to reducing the number of uninsured children, SCHIP and Medicaid enrollment, and access to care. However, even with increases in Healthy Connections enrollment, those increases are not keeping pace with overall SCHIP/Medicaid enrollment.

Idaho has not been able to obtain accurate data on the per cent of children under 12 months receiving preventive care. Much of this has to do with the way that physician offices code visits. Idaho is reexamining the data collection criteria for wellness visits.

Neither the mean nor the mode for length of participation increased this last fiscal year. Idaho is reexamining the data collection methodology for these statistics. Idaho's automated systems do not readily disclose the total length of time for those clients with multiple enrollment periods.

Idaho is focusing efforts to increase participation by both clients and primary care physicians in Healthy Connections over the next 3 to 5 years. A short term plan has been developed to carry the State through the next state fiscal year and is included in Appendix B.

**1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.**

N/A

**1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.**

During the FFY 02, Idaho will continue to track enrollment and access data as it does now and will work to refine accurate, verifiable data for those areas identified in Section 1.4. No further activities are planned due to fiscal constraints.

**1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.**

Appendix A: Idahoans Without Health Insurance, A Data Report  
Appendix B: Healthy Connections Short-term Expansion Plan  
Appendix C: CHIP Enrollment Data  
Appendix D: CareLine Report  
Appendix E: Healthy Connection Survey

## Section 2. Areas of Special Interest

*This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.*

### 2.1 Family coverage:

- A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

N/A

- B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?  
\_\_\_\_\_ Number of adults  
\_\_\_\_\_ Number of children

- C. How do you monitor cost-effectiveness of family coverage?

### 2.2 Employer-sponsored insurance buy-in:

- A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

N/A

- B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?  
\_\_\_\_\_ Number of adults  
\_\_\_\_\_ Number of children

## 2.3 Crowd-out:

### A. How do you define crowd-out in your SCHIP program?

Crowd out is defined as the substitution of enrollment in CHIP for a child's enrollment in a group health plan or other creditable health insurance as defined by HIPAA.

### B. How do you monitor and measure whether crowd-out is occurring?

Idaho has a low-income cap on program eligibility. Information on insurance coverage is asked on the application and quality assurance reviews are conducted monthly. At the time of application, those with creditable health insurance but who are otherwise CHIP eligible are not enrolled.

### C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

Idaho data indicates families are not dropping private health coverage in order to participate in CHIP. Quality assurance reviews conducted monthly by the Idaho Division of Welfare show that less than one percent (0.6%) of applications had an inappropriate approval for CHIP. There are numerous reasons for an inappropriate approval. A family dropping private health care coverage is only one of the many reasons an application may have been approved when the children were ineligible.

### D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

Anti-crowd out policies: The Idaho Legislature and CHIP Task Force were both very concerned about families dropping their health insurance to enroll their children in CHIP. The Legislature in 1998 set the upper income limit for CHIP at 150 percent of the Federal poverty level and reaffirmed that level in its 2000 session. The result of that level is that crowd out has been an insignificant issue in Idaho.

During the enrollment process, questions are asked about the child's participation in other health insurance program as a means of assuring that children with health insurance are not enrolled. Idaho's experience to date is that very few children have insurance at the time of application, which is why their parents are applying for them.

## 2.4 Outreach:

- A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

The state has found a combination of activities effective in reaching low-income, uninsured children. Overall, the structure of the outreach/education plan has been for central office to provide information and education pieces and to support regional grassroots efforts. This complementary approach to outreach and education has utilized resources effectively and provided communities with the knowledge and tools to conduct outreach. The following activities are examples of the type of outreach conducted at the central office level and at the community level.

**Idaho CHIP Outreach Activities Summary Table**

| <b>Activity</b>   | <b>Central Office</b> | <b>Community Based</b> |
|---|-----------------------|------------------------|
| <b>Develop and distribute educational materials i.e. brochures, posters, newsletter articles, website, misc. collateral materials</b> | ✓                     |                        |
| <b>Develop training for families and organizations that work with families and children</b>   | ✓                     |                        |
| <b>Give CHIP educational presentations to families and organizations that work with families and children</b>                         | ✓                     | ✓                      |
| <b>Develop and support outreach/education contracts with the Hispanic and Native American Population</b>                              | ✓                     |                        |
| <b>Attend health fairs &amp; community events</b>   | ✓                     | ✓                      |
| <b>Coordinate CHIP activities with community partners</b>   |                       | ✓                      |
| <b>Provide CHIP information to health care providers i.e. professional conferences, presentations, materials distribution</b>         | ✓                     | ✓                      |
| <b>Develop, manage, and evaluate CHIP/VISTA (Volunteers in Service to America) Project</b>  | ✓                     |                        |
| <b>Provide technical assistance to communities</b>  | ✓                     | ✓                      |
| <b>Provide feedback to Central Office</b>   |                       | ✓                      |

Outreach effectiveness is being measured through enrollment and telephone calls to the resource and referral program, the Idaho Care Line. The combination of outreach and simplification efforts has resulted in an increase of approximately 1,500 children per month in either the Title XIX or Title XXI programs from October 1, 2000 to August 31, 2001.

The total number of calls about CHIP to the Care Line has been 44 percent of the total volume of calls into the Care Line. Major outreach activities are measured through calls to the Care Line and the referral method. For example, if a major school promotion was focused in one area of the state, phone calls from that area with the referral method listed as school could be attributed to the outreach/education effort.

Below are the highest referral methods documented by the CareLine in descending order from the highest to the lowest:

- **Television**
- **Radio**
- **Family or friends**
- **School contacts**
- **“Other” word of mouth, child care provider, Head Start, etc**
- **Medical professional**
- **Other Idaho Department of Health and Welfare Programs**
- **Phonebook/information**
- **Newspaper**

Care Line activity greatly increased in conjunction with major efforts including the Spring RWJ Covering Kids television and radio campaigns in March.

- B. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

Rural families, Hispanic populations, and Native American Families have been identified as target populations to reach. The following table outlines what Idaho has found to be effective forms of outreach/education to reach these populations.

| Target Population   | Outreach/Education Method   |
|---------------------|---|
| Rural families      | <ul style="list-style-type: none"> <li>• Provide applications and information to area schools</li> <li>• Train-the-trainer presentations to school administration, counselors, and nurses</li> <li>• Place CHIP information on independent pharmacy prescription bags</li> <li>• Radio advertisements</li> <li>• Distribute CHIP information at libraries for home schooled children</li> <li>• Post CHIP messages on reader boards and dressing rooms of second hand stores, food stores, post offices, banks, laundry mats, etc</li> <li>• Speaking at service organization meetings</li> </ul> |
| Hispanic population | <ul style="list-style-type: none"> <li>• Attend local festivals and celebrations</li> <li>• Providing information and application assistance door-to-door</li> <li>• Contract education/outreach activities to local organizations that have an existing and trusting relationship with the Hispanic community</li> <li>• Work with migrant Head Start staff</li> </ul>   |
| Native American     | <ul style="list-style-type: none"> <li>• Contract education/outreach activities to tribes</li> <li>• Providing one-on-one information to respected tribal leaders</li> </ul>  |

C. Which methods best reached which populations? How have you measured effectiveness?

Effectiveness has been measured utilizing presentation evaluations, calls to the Idaho CareLine, and in the number of applications the local eligibility offices process.

## 2.5 Retention:

- A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

We implemented a simplified renewal process October 1, 2000. The process includes multiple steps as follows:

**Step One: No Contact** - If we have had contact with the family in the last 60 days we compare the information available from the recent contact with information from interfaces, change reports, or verifications provided for other Department programs. If there are no discrepancies, we renew the coverage and send a coverage continuation letter to the family.

**Step Two: Phone** - If we are unable to complete the renewal using Step One, we complete a personal contact with the family by phone. We compare the information available from the phone contact with information from interfaces, change reports, or verifications provided for other Department programs. If there are no discrepancies, we renew the coverage and send a coverage continuation letter to the family.

**Step Three : Send Renewal Letter** - If we are unable to complete the renewal using Steps One or Two, we conduct an annual renewal by sending or e-mailing a renewal form to the family at least 45 days before their health coverage will end. The form instructs the family to review the information entered by their worker on the form, provide any updated information, sign and return the form or call and report that there are no changes within 10 days of receiving the form or the 5th of the following month.

**Option Four : Interview** - If the family requests or the Self Reliance worker feels it would benefit the family, a face to face interview can be arranged. Families can not lose coverage for failure to attend a face to face interview.

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

\_\_\_ Follow-up by caseworkers/outreach workers

\_\_\_ Renewal reminder notices to all families

\_\_\_ Targeted mailing to selected populations, specify population

\_\_\_ Information campaigns

**X** Simplification of re-enrollment process, please describe (**see Section 2.5.A**)

\_\_\_ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe

\_\_\_ Other, please explain

C. Are the same measures being used in Medicaid as well? If not, please describe the differences. **Yes**

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled? **The simplified renewal process.**

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

**Idaho does not track this information.**

## **2.6 Coordination between SCHIP and Medicaid:**

- A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

Yes, all the processes are exactly the same.

- B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

Children are granted 12 months continuous eligibility. Children are moved between Medicaid and SCHIP at renewal only.

- C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Yes, SCHIP is a Medicaid expansion program in Idaho. Participation in SCHIP vs Medicaid is transparent to the health care delivery system, including providers.

## **2.7 Cost Sharing:**

- A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

No

- B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

No

## **2.8 Assessment and Monitoring of Quality of Care:**

- A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

Idaho received a state planning grant for the uninsured from HRSA in the spring of 2001. As part of the grant activities, a series of focus groups were conducted in the fall of 2001 with employees of small business who do not have insurance. One of the consistent findings of these groups was that most of uninsured who had children had enrolled their children in the Idaho Children's Health Insurance Program. Of those families reporting that they were enrolled in CHIP, there was a high satisfaction level with both the enrollment process and the services provided to the children.

- B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

Idaho is currently in the process of instilling and implementing a care management perspective in regard to service delivery for its Medicaid population to enhance quality of care.

The Healthy Connections program conducts an annual survey of client participants. Currently, approximately one-third of SCHIP enrollees participate in Healthy Connections. Many questions of this survey are geared to assess aspects of access to care. The 2001 survey indicates a slight increase in waiting times for appointments and a slight decrease in distance to the primary care physician's office (See Appendix F). As Idaho focuses on increasing Healthy Connections participation, the annual survey results will come closer to reflecting the entire SCHIP population.

- C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

Idaho is currently conducting a survey of all primary care practices in the State to more closely ascertain where access issues exist. This data should be compiled and information available in July 2002.

Idaho is currently working to develop the methodology for incorporating disease management into the existing system. Pediatric asthma and diabetes are targeted as a starting point. It is not clear at this time when data will become available.

The Healthy Connections participant survey will continue to be used to monitor access to care and more questions regarding quality will be incorporated in the next survey. This data should be available in November 2002.

### SECTION 3. SUCCESSES AND BARRIERS

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*This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.*

**3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.**

*Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.*

A. Eligibility- N/A

B. Outreach

A significant barrier Idaho has experienced is being able to provide federal matching funds for outreach and education conducted through RWJ Covering Kids. CMS categorizing this activity as a provider related match has resulted in fewer families and organization learning about CHIP and receiving application assistance.

C. Enrollment

Idaho has attained the four year goal established October 1999, of enrolling 8,000 children per year for four years in either Medicaid or CHIP in April 2001. Enrollment increased from 55,006 in Medicaid and CHIP in October 1999 to 94,965 children enrolled in Medicaid and CHIP in September 2001.

D. Retention/disenrollment – N/A

E. Benefit structure – N/A

F. Cost-sharing – N/A

G. Delivery system

Idaho has found success in working with hospitals, provider organizations, and providers. Examples of this include:

- All major hospitals have CHIP applications available and can assist families in completing the application.
- The Idaho State Dental Association has partnered with DHW in an effort to improve dental access for CHIP participants.
- A majority of primary care providers have been focused on providing CHIP participants with a medical home and encouraging parents to apply for CHIP.

H. Coordination with other programs

CHIP is a Medicaid expansion in Idaho. The CHIP and the Family Medicaid programs are being marketed as one program. If a child's family income is less than 150 percent of the Federal poverty limit and the family meets the asset test, that child is eligible for the Children's Health Insurance Program. The Medicaid or CHIP coverage group is invisible to the participant.

This has done a great deal to eliminate the stigma of "Medicaid" for families. The result is the dramatic increase in enrollment for Idaho's children. The positive features of this choice are as follows:

- Outreach could be for the single Idaho Children's Health Insurance Program rather than for a Medicaid program and the separate CHIP program
- Children do not disenroll because of problems in transferring eligibility between the two programs since the eligibility rules are the same.
- The program is easy for the public to understand leading to broader public and political support.
- It is more cost effective both in terms of media activities as noted in outreach above and in terms of ease of administration. Eligibility workers only need to learn one set of rules.
- While access is a problem in Idaho, we believe the combined program enhances access by facilitating provider participation in one program through ease of understanding one set of rules and billing procedures.

I. Crowd-out – N/A

J. Other – N/A

## SECTION 4: PROGRAM FINANCING

*This section has been designed to collect program costs and anticipated expenditures.*

- 4.1 **Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.**

*Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).*

|  | Federal Fiscal Year<br>2001 costs | Federal Fiscal<br>Year 2002 | Federal Fiscal Year<br>2003 |
|--|-----------------------------------|-----------------------------|-----------------------------|
| <b>Benefit Costs</b>                               |                                   |                             |                             |
| Insurance payments                                 |                                   |                             |                             |
| Managed care                                       |                                   |                             |                             |
| per member/per month rate X #<br>of eligibles      |                                   |                             |                             |
| Fee for Service                                    | 14,696,689                        | 18,119,000                  | 18,966,000                  |
| Total Benefit Costs                                | 14,696,689                        | 18,119,000                  | 18,966,000                  |
| (Offsetting beneficiary cost sharing payments)     |                                   |                             |                             |
| Net Benefit Costs                                  | 14,696,689                        | 18,119,000                  | 18,966,000                  |
|  |                                   |                             |                             |
| <b>Administration Costs</b>                        |                                   |                             |                             |
| Personnel  | 149,096                           | 180,052                     | 188,469                     |
| General administration                             | 1,457,067                         | 1,796,344                   | 1,880,317                   |
| Contractors/Brokers (e.g., enrollment contractors) |                                   |                             |                             |
| Claims Processing                                  |                                   |                             |                             |
| Outreach/marketing costs                           | 180,024                           | 222,042                     | 232,422                     |
| Other  |                                   |                             |                             |
| Total Administration Costs                         | 1,783,187                         | 2,198,438                   | 2,301,208                   |
| 10% Administrative Cost Ceiling                    | 1,632,965                         | 2,013,222                   | 2,107,333                   |
|  |                                   |                             |                             |
| Federal Share (multiplied by enhanced FMAP rate)   | 12,986,974                        | 16,047,394                  | 16,835,486                  |
| State Share  | 3,342,680                         | 4,084,828                   | 4,237,847                   |
| <b>TOTAL PROGRAM COSTS</b>                         | <b>16,329,654</b>                 | <b>20,132,222</b>           | <b>21,073,333</b>           |

**4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001. N/A**

**4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?**

- ☒ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations (such as United Way, sponsorship)
- ☐ Other (specify)

**A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.**

**No**

## SECTION 5: SCHIP PROGRAM AT-A-GLANCE

*This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.*

**5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information.** If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

| Table 5.1   | Medicaid Expansion SCHIP program   | Separate SCHIP program  |
|---|--|---|
| Program Name  |  |   |
| Provides presumptive eligibility for children                                   | <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Yes, for whom and how long?   | <input type="checkbox"/> No<br><input type="checkbox"/> Yes, for whom and how long?   |
| Provides retroactive eligibility  | <input type="checkbox"/> No<br><input checked="" type="checkbox"/> Yes, for whom and how long?<br>Upon request of applicant, up to 3 months if found eligible  | <input type="checkbox"/> No<br><input type="checkbox"/> Yes, for whom and how long?   |
| Makes eligibility determination   | <input checked="" type="checkbox"/> State Medicaid eligibility staff<br><input type="checkbox"/> Contractor<br><input type="checkbox"/> Community-based organizations<br><input type="checkbox"/> Insurance agents<br><input type="checkbox"/> MCO staff<br><input type="checkbox"/> Other (specify) | <input type="checkbox"/> State Medicaid eligibility staff<br><input type="checkbox"/> Contractor<br><input type="checkbox"/> Community-based organizations<br><input type="checkbox"/> Insurance agents<br><input type="checkbox"/> MCO staff<br><input type="checkbox"/> Other (specify) |
| Average length of stay on program   | Specify months: <u>9</u>   | Specify months  |
| Has joint application for Medicaid and SCHIP                                    | <input type="checkbox"/> No<br><input checked="" type="checkbox"/> Yes   | <input type="checkbox"/> No<br><input type="checkbox"/> Yes   |
| Has a mail-in application   | <input type="checkbox"/> No<br><input checked="" type="checkbox"/> Yes   | <input type="checkbox"/> No<br><input type="checkbox"/> Yes   |
| Can apply for program over phone  | <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Yes   | <input type="checkbox"/> No<br><input type="checkbox"/> Yes   |
| Can apply for program over internet   | <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Yes   | <input type="checkbox"/> No<br><input type="checkbox"/> Yes   |
| Requires face-to-face interview during initial application                      | <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Yes   | <input type="checkbox"/> No<br><input type="checkbox"/> Yes   |
| Requires child to be uninsured for a minimum amount of time prior to enrollment | <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Yes, specify number of months<br>What exemptions do you provide?  | <input type="checkbox"/> No<br><input type="checkbox"/> Yes, specify number of months<br>What exemptions do you provide?  |

| Table 5.1  | Medicaid Expansion SCHIP program   | Separate SCHIP program  |
|--|--|---|
| Provides period of continuous coverage <u>regardless of income changes</u> | <p><input type="checkbox"/> No<br/> <input checked="" type="checkbox"/> Yes, specify number of months<br/> <b>12 months</b><br/>           Explain circumstances when a child would lose eligibility during the time period</p> <p><b>Loss of residency</b><br/> <b>19<sup>th</sup> birthday</b><br/> <b>SSN doesn't verify</b><br/> <b>Information on application found to be incorrect</b></p> | <p><input type="checkbox"/> No<br/> <input type="checkbox"/> Yes, specify number of months<br/>           Explain circumstances when a child would lose eligibility during the time period</p>  |
| Imposes premiums or enrollment fees  | <p><input checked="" type="checkbox"/> No<br/> <input type="checkbox"/> Yes, how much?<br/>           Who Can Pay?<br/> <input type="checkbox"/> Employer<br/> <input type="checkbox"/> Family<br/> <input type="checkbox"/> Absent parent<br/> <input type="checkbox"/> Private donations/sponsorship<br/> <input type="checkbox"/> Other (specify)</p>   | <p><input type="checkbox"/> No<br/> <input type="checkbox"/> Yes, how much?<br/>           Who Can Pay?<br/> <input type="checkbox"/> Employer<br/> <input type="checkbox"/> Family<br/> <input type="checkbox"/> Absent parent<br/> <input type="checkbox"/> Private donations/sponsorship<br/> <input type="checkbox"/> Other (specify)</p> |
| Imposes copayments or coinsurance  | <p><input checked="" type="checkbox"/> No<br/> <input type="checkbox"/> Yes</p>  | <p><input type="checkbox"/> No<br/> <input type="checkbox"/> Yes</p>  |
| Provides preprinted redetermination process                                | <p><input type="checkbox"/> No<br/> <input checked="" type="checkbox"/> Yes, we send out form to family with their information precompleted and:<br/> <input checked="" type="checkbox"/> ask for a signed or verbal confirmation that information is still correct<br/> <input type="checkbox"/> do not request response unless income or other circumstances have changed</p>                  | <p><input type="checkbox"/> No<br/> <input type="checkbox"/> Yes, we send out form to family with their information and:<br/> <input type="checkbox"/> ask for a signed confirmation that information is still correct<br/> <input type="checkbox"/> do not request response unless income or other circumstances have changed</p>            |

## 5.2 Please explain how the redetermination process differs from the initial application process.

The initial application process and the renewal process are virtually identical. The Self Reliance worker collects information from interfaces and other sources to compare with the information on the application. Discrepancies are resolved and an eligibility decision is provided to the family.

## Section 6: Income Eligibility

*This section is designed to capture income eligibility information for your SCHIP program.*

- 6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group?**  
If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

**Title XIX Child Poverty-related Groups or  
Section 1931-whichever category is higher**

133% of FPL for children under age 6

100% of FPL for children aged 6 to 19 born after 9/30/83

**Medicaid SCHIP Expansion**

150% of FPL for children aged birth to 19

**Separate SCHIP Program - N/A**

- 6.2 As of September 30, 2001, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income?** *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)

\_\_\_\_\_ Yes    XX No

If yes, please report rules for applicants (initial enrollment).

| <b>Table 6.2</b>                               |  |                          |                        |
|--|--|--------------------------|------------------------|
|  | Title XIX Child Poverty-related Groups   | Medicaid SCHIP Expansion | Separate SCHIP Program |
| Earnings                                       | \$ 90, also, rarely, \$30 + 1/3  | \$ None                  | \$                     |
| Self-employment expenses                       | 50% of gross earning after the cost of goods sold are deducted or actual costs- whichever is more beneficial to the family |                          | \$                     |
| Alimony payments Received                      | \$   | \$ None                  | \$                     |
| Paid   | \$   | \$ None                  | \$                     |
| Child support payments Received                | \$   | \$ None                  | \$                     |
| Paid   | \$   | \$ None                  | \$                     |
| Child care expenses                            | \$   | \$ None                  | \$                     |
| Medical care expenses                          | \$   | \$ None                  | \$                     |
| Gifts  | \$   | \$ None                  | \$                     |
| Other types of disregards/deductions (specify) | \$   | \$ None                  | \$                     |

### 6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

☐ No ☒ Yes, specify countable or allowable level of asset test

\$1,000 for AF Related Programs

\$5,000 for FPG Related Programs

Medicaid SCHIP Expansion program

☐ No ☒ Yes, specify countable or allowable level of asset test

\$5,000 for CHIP

Separate SCHIP program –N/A

☐ No ☐ Yes, specify countable or allowable level of asset test \_\_\_\_\_

Other SCHIP program ☐ N/A \_\_\_\_\_

☐ No ☐ Yes, specify countable or allowable level of asset test \_\_\_\_\_

### 6.4 Have any of the eligibility rules changed since September 30, 2001?

☐ Yes ☒ No

## **SECTION 7: FUTURE PROGRAM CHANGES**

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*This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.*

- 7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001( 10/1/00 through 9/30/01)?** Please comment on why the changes are planned.
- A. Family coverage- **N/A**
  - B. Employer sponsored insurance buy-in – **N/A**
  - C. 1115 waiver- **N/A**
  - D. Eligibility including presumptive and continuous eligibility – **N/A**
  - E. Outreach – Restriction on the type of outreach conducted due to State legislative directive. Mass media will not be utilized by the Department until further direction received. Other entities have stepped in to help continue mass media efforts.
  - F. Enrollment/redetermination process – **N/A**
  - G. Contracting- Number of outreach contracts reduced due to budget issues. Contracts will still be granted to conduct focused outreach to Idaho's Native American and Hispanic populations.
  - H. Other- Increase enrollment in Idaho's managed care program, Healthy Connections, to help ensure that each child has a medical home.